# UTAH ACCIDENT & HEALTH SURVEY (ASO SUPPLEMENT) INSTRUCTIONS

The ASO Supplement is a follow-up survey for the 2019 Utah Accident & Health Survey. All responses will be recorded as answers to the 2019 Utah Accident & Health Survey. All companies who reported Administrative Services business on part 5-A of the 2019 Utah Accident & Health Survey must complete and submit the ASO Supplement. Please note that this survey applies only to 2019 business. If you do not have any Administrative Services business and reported zero on part 5-A of the 2019 Utah Accident & Health Survey then you are exempt from filing the ASO Supplement and should not file this form. "None" reports are not required. Just file the 2019 Utah Accident & Health Survey without the ASO Supplement.

This follow-up survey is designed to collect data on Administrative Services in greater detail. All data values reported on the survey form should represent the year-end totals of the report year (December 31, 2019) and balance to the data previously reported on parts 5-A and 5-B of the Utah Accident & Health Survey for 2019.

The completed survey form should be sent to the Utah Insurance Department **by April 1, 2020**. All submissions should be made via the UID secure file upload website at https://forms.uid.utah.gov/insurance/fileUploads/. Any other forms of data submission are not acceptable. Failure to file by the deadline may subject your company to the enforcement penalties under Utah Code § 31A-2-308. Any questions on completing this survey form should be directed to Daron Funn, Research Assistant via email to uid.healthresearch@utah.gov.

The survey form is divided into four major parts:

In part 1-A, companies report membership and claim data for administrative services of self-funded health benefit plans in Utah during 2019.

In part 1-B, companies report additional detail for certain types of administrative services. This category was created for a select number of companies with special circumstances. Most companies will not need to use this category.

In parts 2 and 3, companies with Administrative Services for self-funded health benefit plans in Utah provide additional detail regarding employee health benefit plans. The information reported here should be internally consistent and balance to the information reported in part 1-A.

In part 4-A through 4-D, companies report Stop-Loss insurance coverage data for self-funded health benefit plans in Utah. The information reported here should be internally consistent and balance to the information reported in part 2.

**SIGNATURE FORM**

The last component of the follow-up survey is the Signature Form. The Utah Insurance Department collects the Utah Accident & Health Survey with the intent and understanding that these records are classified as protected records under § 63G-2-305(2). The Signature Form should be filed along with this follow-up survey. This signature form ensures that the data is properly classified as a protected record under § 63G-2-305(2). In order to ensure this data is properly classified, please sign and date the Signature Form and return it to the Utah Insurance Department. Each company should file one signature form per survey filing. This Signature Form covers data your company may have sent to the Utah Insurance Department during 2019 for the Utah Accident & Health Survey and any of the follow up survey supplements, including the Short-Term Limited Duration Supplement, Stop-Loss Supplement, and ASO Supplement.

***PART 1-A: ADMINISTRATIVE SERVICES FOR UTAH SELF-FUNDED HEALTH BENEFIT PLANS***

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| SELF-FUNDED HEALTH BENEFIT PLANS: | This category refers to any administrative business (third party administration, administrative services only or administrative services contract) with a self-funded or ERISA eligible employer-sponsored health benefit plan in the State of Utah. Plans included here should function as the primary health benefit plan of the covered member. The data reported here should balance to part 5-A of the 2019 Utah Accident & Health Survey. |

**COLUMN DEFINITIONS**

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|---|---|
| NUMBER OF MEMBERS: | Enter the total number of members in self-funded health benefit plans administered by the insurer. |
| ADMIN. INCOME: | Enter the total dollar amount of administrative income received by the insurer for administrating self-funded health benefit plans. |
| TOTAL CLAIMS PAID: | Enter the total dollar amount of claims processed by the insurer while administrating self-funded health benefit plans. |

**ROW DEFINITIONS**

| | |
|---|---|
| INDEMNITY / FEE FOR SERVICE PLAN (FFS): | Under a Traditional Indemnity or Fee For Service plan (FFS), the member can use any provider they choose (as long as the services are a covered benefit under the health benefit plan). There are no preferred provider networks and all services are reimbursed at the same cost sharing level (usually a fixed percentage of billed charges) regardless of which provider they choose. The member usually has a fixed coinsurance rate above the deductible.<br><br>However, if the FFS plan includes a PPO rider that allows individuals to pay a lower co-payment or coinsurance rate when they visit doctors or obtain medical services from a network of preferred providers, then the plan should be classified as a PPO for the purposes of the survey (see “Preferred Provider Organization Plan (PPO):”). |
| PREFERRED PROVIDER ORGANIZATION PLAN (PPO): | Under a Preferred Provider Organization plan (PPO), the member has lower deductibles and coinsurance if they use physicians or hospitals in the preferred provider network. PPOs cannot limit members to the preferred provider network only, as this would be an EPO arrangement and PPOs are prohibited from doing this under Utah code. Rather, members have a financial incentive to stay within the preferred provider network, as costs are lower if they use preferred providers. Members are free to use any provider outside the network, but services are reimbursed at a lower rate and typically members must pay higher costs to do so.<br><br>In the past, if the PPO plan required permission from a primary physician or gatekeeper, or required some other form of pre-authorization prior to receiving services from a non-preferred provider that is outside of the network, then the plan was classified as a PPO with POS features for the purposes of the survey. Any PPO with POS feature plans should be classified as a PPO plan. Do not put PPO with POS feature plans in “Other”; classify them as “PPO”. |
| EXCLUSIVE PROVIDER ORGANIZATION PLAN (EPO): | Under an Exclusive Provider Organization plan (EPO), the insured member must use the EPO network providers exclusively, except in the case of an emergency. No services outside of the EPO network are covered. EPO plans are similar to HMO plans in that services are limited to an exclusive set of network providers. EPO plans differ from HMO plans in that they are being offered by a standard accident & health insurance carrier that may offer PPO plans along with EPO plans and does not qualify as a licensed HMO (see “Preferred Provider Organization Plan (PPO):” and also “Health Maintenance Organization Plan (HMO):”). |

***PART 1-A: ADMINISTRATIVE SERVICES FOR UTAH SELF-FUNDED HEALTH BENEFIT PLANS (CONTINUED)***

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| HEALTH MAINTENANCE ORGANIZATION PLAN (HMO): | Under a Health Maintenance Organization plan (HMO), the member must use the HMO network providers exclusively, except in the case of an emergency. No services provided outside of the HMO network are covered. However, if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers), then the plan should be classified as HMO with POS features for the purposes of the survey. |
| HEALTH MAINTENANCE ORGANIZATION PLAN WITH POINT OF SERVICE FEATURES (POS): | Special category for certain types of HMOs. Use this category if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers). See also "Health Maintenance Organization Plan (HMO):" |
| OTHER PLANS: | Use the all other category for plans that do not fit into any of the previous categories. If this category is used, you should include a brief description of the plan features and explain why the other categories are not applicable. PPO with POS features plans should not go in this category, put them in the PPO category. This category should not be used at all in most cases, as Utah Self-Funded Health Benefit plans filed for use should qualify for one of the other categories. |

***PART 1-B: ADMINISTRATIVE SERVICES FOR FEHBP, MEDICARE, MEDICAID, DENTAL, AND VISION***

You should only complete this section if your company provides administrative services only (ASO), administrative services contracts (ASC) and other non-underwritten administrative business related to the Federal Employee Health Benefit Plan (FEHBP), Utah Medicaid, Federal Medicare programs, self-funded dental benefit plans, self-funded vision benefit plans, or other type of administrative services that the Utah Insurance Department needs additional information on. Exclude all business reported under self-funded health benefit plans. All data should be current as of December 31, 2019, and balance to the data reported on part 5-B of the 2019 Utah Accident & Health Survey. Most companies that need this category have already been instructed to use it. If you have questions on whether you should use this category, contact Daron Funn at uid.healthresearch@utah.gov.

**PART 2: UTAH SELF-FUNDED HEALTH BENEFIT PLANS**

**COLUMN DEFINITIONS**

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|---|---|
| NUMBER OF MEMBERS: | Enter the total number of members in self-funded health benefit plans administered by the insurer. The number of members must include dependents. For group policies, the number of members must equal the number of subscribers plus dependents. |
| CUMULATIVE MEMBER MONTHS: | Enter the cumulative year-end member months for each Utah Self-Funded Health Benefit Plan category. If you report self-funded health benefit plan business, you must report member months, even if the members is zero at the end of the calendar year. To calculate member months, first count the number of members during each month of the year. This produces 12 member counts (one for each month). Then sum total all 12 member counts. This total is the cumulative member months for the year. For example, if your company had 10 members during each of the 12 months of the year, the cumulative member months would be calculated as follows: 10 members x 12 months = 120 member months. |
| NUMBER OF SUBSCRIBERS: | Subscriber (also called certificate holder) refers to the individual whose eligibility is the basis for the enrollment in the individual or group health plan and/or who is responsible for the payment of premiums. |
| NUMBER OF DEPENDENTS: | A covered member who relies on another member (typically the subscriber) for support or obtains health coverage through a spouse or parent who is the primary covered member or subscriber under a health plan. |

**PART 2: UTAH SELF-FUNDED HEALTH BENEFIT PLANS (CONTINUED)**

NUMBER OF GROUPS: This is the total number of employer groups covered as of the last day of the reporting period. This is not a count of the number of subscribers. Enter the total number of employer groups for each row category. "Number of Groups" means a count of the number of employer groups with a particular type of health benefit plan. Unlike the other column categories, the counts in this column may not necessarily add up to the total number of groups reported in the subtotals and totals for a particular table. For example, in Table 2, if a single group (1) had a FFS plan (line 3.1), a PPO plan (line 3.2), an EPO plan (line 3.3), a HMO plan (line 3.4), and a POS plan (line 3.5) the total number of groups (line 3.7) would still be one (1), not five (5) because there is still only one employer being covered even though the employer has four separate health benefit plans. The unit of analysis is the employer group, not the health benefit plan. So in contrast to the other column categories, this column may not sum total due to double counting. Instead, report the actual number of employer groups that would be true for each row category.

TOTAL CLAIMS PAID (DOLLARS): Enter the total dollar amount of claims processed by the insurer while administrating self-funded health benefit plans. Line 4.7 must balance line 7, part 1-A.

**ROW DEFINITIONS**

*Group Categories*

SMALL GROUP (1 to 50): Policies issued to a group organization of 1 to 50 employees.

LARGE GROUP (51 to 100): Policies issued to a group organization of 51 to 100 employees.

LARGE GROUP (101 or more): Policies issued to a group organization of 101 or more employees.

TOTAL: Total of Small Group and Large Group categories. Note: Column 5 “Number of Groups” may not necessarily add up to the total number of groups reported in the subtotals of lines 1.7, 2.7, 3.7, and 4.7. Please see the definition of “Number of Groups” for more information.

**PLAN CATEGORIES**

INDEMNITY / FEE FOR SERVICE PLAN (FFS): Under a Traditional Indemnity or Fee For Service plan (FFS), the member can use any provider they choose (as long as the services are a covered benefit under the health benefit plan). There are no preferred provider networks and all services are reimbursed at the same cost sharing level (usually a fixed percentage of billed charges) regardless of which provider they choose. The member usually has a fixed coinsurance rate above the deductible.

However, if the FFS plan includes a PPO rider that allows individuals to pay a lower co-payment or coinsurance rate when they visit doctors or obtain medical services from a network of preferred providers, then the plan should be classified as a PPO for the purposes of the survey (see “Preferred Provider Organization Plan (PPO):”).

PREFERRED PROVIDER ORGANIZATION PLAN (PPO): Under a Preferred Provider Organization plan (PPO), the member has lower deductibles and coinsurance if they use physicians or hospitals in the preferred provider network. PPOs cannot limit members to the preferred provider network only, as this would be an EPO arrangement and PPOs are prohibited from doing this under Utah code. Rather, members have a financial incentive to stay within the preferred provider network, as costs are lower if they use preferred providers. Members are free to use any provider outside the network, but services are reimbursed at a lower rate and typically members must pay higher costs to do so.

In the past, if the PPO plan required permission from a primary physician or gatekeeper, or required some other form of pre-authorization prior to receiving services from a non-preferred provider that is outside of the network, then the plan was classified as a PPO with POS features for the purposes of the survey. Any PPO with POS feature plans should be classified as a PPO plan. Do not put PPO with POS feature plans in “Other”, classify them as “PPO”.

**PART 2: UTAH SELF-FUNDED HEALTH BENEFIT PLANS (CONTINUED)**

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|---|---|
| EXCLUSIVE PROVIDER ORGANIZATION PLAN (EPO): | Under an Exclusive Provider Organization plan (EPO), the insured member must use the EPO network providers exclusively, except in the case of an emergency. No services outside of the EPO network are covered. EPO plans are similar to HMO plans in that services are limited to an exclusive set of network providers. EPO plans differ from HMO plans in that they are being offered by a standard accident & health insurance carrier that may offer PPO plans along with EPO plans and does not qualify as a licensed HMO (see "Preferred Provider Organization Plan (PPO):" and also "Health Maintenance Organization Plan (HMO):"). |
| HEALTH MAINTENANCE ORGANIZATION PLAN (HMO): | Under a Health Maintenance Organization plan (HMO), the member must use the HMO network providers exclusively, except in the case of an emergency. No services provided outside of the HMO network are covered. Only licensed HMOs can offer HMO plans in Utah. However, if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers), then the plan should be classified as HMO with POS features for the purposes of the survey. |
| HEALTH MAINTENANCE ORGANIZATION PLAN WITH POINT OF SERVICE FEATURES (POS): | Special category for certain types of HMOs. Use this category if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers). See also "Health Maintenance Organization Plan (HMO):" |
| OTHER PLANS: | Use the all other category for plans that do not fit into any of the previous categories. If this category is used, you should include a brief description of the plan features and explain why the other categories are not applicable. PPO with POS features plans should not go in this category, put them in the PPO category. This category should not be used at all in most cases, as Utah self-funded health benefit plans should qualify for one of the other categories. |

**PART 3: STANDARD VS HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLANS**

**COLUMN DEFINITIONS**

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|---|---|
| NUMBER OF MEMBERS: | Enter the total number of members in self-funded health benefit plans administered by the insurer. The number of members must include dependents. For group policies, the number of members must equal the number of subscribers plus dependents. |
| CUMULATIVE MEMBER MONTHS: | Enter the cumulative year-end member months for each Utah Self-Funded Health Benefit Plan category. If you report self-funded health benefit plan business, you must report member months, even if the members is zero at the end of the calendar year. To calculate member months, first count the number of members during each month of the year. This produces 12 member counts (one for each month). Then sum total all 12 member counts. This total is the cumulative member months for the year. For example, if your company had 10 members during each of the 12 months of the year, the cumulative member months would be calculated as follows: 10 members x 12 months = 120 member months. |
| NUMBER OF SUBSCRIBERS: | Subscriber (also called certificate holder) refers to the individual whose eligibility is the basis for the enrollment in the individual or group health plan and/or who is responsible for the payment of premiums. |
| NUMBER OF DEPENDENTS: | A covered member who relies on another member (typically the subscriber) for support or obtains health coverage through a spouse or parent who is the primary covered member or subscriber under a health plan. |

**PART 3: STANDARD VS HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLANS (CONTINUED)**

NUMBER OF GROUPS: This is the total number of employer groups covered as of the last day of the reporting period. This is not a count of the number of subscribers. Enter the total number of employer groups for each row category. "Number of Groups" means a count of the number of employer groups with a particular type of health benefit plan. Unlike the other column categories, the counts in this column may not necessarily add up to the total number of groups reported in the subtotals and totals for a particular table. For example, in Table 3, if a single group (1) had a Standard plan (line 1.1) and a HSA-Qualified HDHP plan, the total number of groups (line 1.3) would still be one (1), not two (2) because there is still only one employer being covered even though the employer has two separate health benefit plans. The unit of analysis is the employer group, not the health benefit plan. So in contrast to the other column categories, this column may not sum total due to double counting. Instead, report the actual number of employer groups that would be true for each row category.

TOTAL CLAIMS PAID (DOLLARS): Enter the total dollar amount of claims processed by the insurer while administrating self-funded health benefit plans.

**ROW DEFINITIONS**

*Group Categories*

SMALL GROUP (1 to 50): Policies issued to a group organization of 1 to 50 employees.

LARGE GROUP (51 to 100): Policies issued to a group organization of 51 to 100 employees.

LARGE GROUP (101 or more): Policies issued to a group organization of 101 or more employees.

TOTAL: Total of Small Group and Large Group categories. Note: Column 5 “Number of Groups” may not necessarily add up to the total number of groups reported in the subtotals of lines 1.3, 2.3, 3.3, and 4.3. Please see the definition of “Number of Groups” for more information.

*Product Categories*

STANDARD: These are standard employee health benefit plans that have been traditionally offered in Utah by self-funded groups. These plans are not subject to state mandates or plan requirements described by under the Utah Insurance Code. Exclude HSA-Qualified HDHP plans.

HSA-QUALIFIED HDHP: Any High Deductive Health Plan that is eligible for use with a Health Savings Account (HSA). Exclude any plan that is not a HSA-Qualified HDHP plan (e.g., All traditional health plans).

**PART 4: STOP-LOSS INSURANCE COVERAGE**

STOP-LOSS INSURANCE COVERAGE: “Stop-loss insurance” means insurance purchased for which the stop-loss insurer assumes, on per-loss basis, the risk of loss of a group health benefit plan in excess of a stated amount, subject to the policy limit. Stop-loss insurance may include either specific stop-loss limits (see “Specific Attachment Point”) and/or aggregate stop-loss limits (see “Aggregate Attachment Point”). Stop-loss insurance products provide protection against catastrophic or unpredictable losses for employer group health benefit plans. Stop-loss coverage is purchased by employers or administrators of group health benefit plans that do not want to assume 100% of the liability for losses arising from the plans. Stop-loss coverage is often a feature of unfunded and self-funded plans where the employer assumes the risk of health care costs up to certain limits on individual claims (specific) or up to a certain limit on all claims combined (aggregate). An employer or group health benefit plan administrator pays an insurance company to assume the risk above the specific and aggregate levels. Overall, stop-loss coverage can limit the employer’s or group health benefit plan’s risk while allowing it to retain control over claims and benefits. Specific stop-loss focuses on the severity of extreme claims (a single individual or claim in excess of the specific deductible), while aggregate stop-loss focuses on the frequency of extreme claims (the total cost of claims in excess of the aggregate deductible).

SPECIFIC STOP-LOSS: Limits the employer group's cost for eligible medical expenses for each covered individual (also known as individual stop-loss, individual attachment point, or individual deductible). The minimum attachment point is usually set based on the stop-loss carrier's review of the group's demographics, expected claims, and past losses, and the employer group's risk tolerance. The optimal specific stop-loss limit is often based on a percentage of the expected claims.

SPECIFIC ATTACHMENT POINT: The Specific Attachment Point is the specified limit when a stop-loss insurance contract will pay for an individual or claim. This limit is the threshold at which medical claims become payable from the assets of the stop-loss carrier for the remainder of the policy year for an individual. Also referred to as Specific Limit or Individual Stop-Loss Deductible.

AGGREGATE STOP-LOSS: Insurance that protects against an unusually high frequency of medium and large claims for the entire group. It provides a limit on the dollar amount of eligible expenses that an employer or group health benefit plan would pay, in total, during a contract period.

AGGREGATE ATTACHMENT POINT: The Aggregate Attachment Point is the specified limit when a stop-loss insurance contract will pay for a group's excess claims. This limit is the threshold at which medical claims become payable from the assets for the stop-loss carrier for the remainder of the policy year when claims for the group as a whole exceed the limits based on the factors outlined in the policy. No payments are made until the sum of all paid claims for the contract period exceeds a predetermined limit or aggregate attachment point. This limit is based on the expected claim costs (often based on an evaluation of claims from previous years and a projection of expected claims from the coming year). The Aggregate Attachment Point is often expressed as an aggregate factor or margin (e.g., 100 percent of expected claims plus a 25 percent margin). The stop-loss carrier begins paying out after the aggregate stop-loss funding level (e.g., 125 percent of expected claims) is reached.

***PART 4-A: STOP-LOSS INSURANCE COVERAGE***

This table is a measure of the number of individual members and groups that are in a self-funded health benefit plan covered by any type of stop-loss insurance.

**COLUMN DEFINITIONS**

NUMBER OF MEMBERS COVERED: Enter the total number of members in a self-funded health benefit plan administered by the insurer that is covered by any type of stop-loss insurance.

NUMBER OF GROUPS COVERED: Enter the total number of groups in a self-funded health benefit plans administered by the insurer that is covered by any type of stop-loss insurance. Enter the total number of employer groups for each row category. "Number of Groups" means a count of the number of employer groups with a particular type of health benefit plan. Unlike the other column categories, the counts in this column may not necessarily add up to the total number of groups reported in the subtotals and totals for a particular table. For example, in Table 4-A, if a single group (1) had plan with Stop-Loss coverage (line 1.1) and a plan without Stop-Loss coverage (line 1.2), the total number of groups (line 1.3) would still be one (1), not two (2) because there is still only one employer being covered even though the employer has two separate health benefit plans. The unit of analysis is the employer group. So in contrast to the other column categories, this column may not sum total due to double counting. Instead, report the actual number of employer groups that would be true for each row category.

**ROW DEFINITIONS**

WITH STOP-LOSS COVERAGE: Enter the total number of members and groups in a self-funded health benefit plan administered by the insurer that is covered by any type of stop-loss insurance.

WITHOUT STOP-LOSS COVERAGE: Enter the total number of members and groups in a self-funded health benefit plan administered by the insurer that does not have any type of stop-loss insurance coverage.

TOTAL: Enter the total number of members and groups in self-funded health benefit plans administered by the insurer. Note: Column 2 "Number of Groups Covered" may not necessarily add up to the total number of groups reported in the subtotals of lines 1.3. Please see the definition of "Number of Groups" for more information. Line 1.3 should balance to the number of members and groups reported in line 4.6, part 2.

***PART 4-B: STOP-LOSS INSURANCE SPECIFIC ATTACHMENT POINTS***

This table is a measure of the number of individual members and groups that are in a self-funded health benefit plan covered by stop-loss insurance coverage broken out by specific attachment points (see Specific Attachment Points). It does not measure aggregate attachment points (see Aggregate Attachment Points).

**COLUMN DEFINITIONS**

NUMBER OF MEMBERS COVERED: Enter the total number of members in a self-funded health benefit plan administered by the insurer that is covered by stop-loss insurance broken out by a specific attachment point (individual stop-loss deductible). The total number of members covered in part 4-B, line 1.22, columns 1, 3, and 5 must balance to the total number of members covered in part 4-A, line 1.1, column 1.

NUMBER OF GROUPS COVERED: Enter the total number of groups in a self-funded health benefit plan administered by the insurer that is covered by stop-loss insurance broken out by a specific attachment point (individual stop-loss deductible). "Number of Groups Covered" means a count of the number of employer groups with a particular type of health benefit plan. Unlike the other column categories, the counts in this column may not necessarily add up to the total number of groups reported in the subtotals and totals for a particular table. For example, in part 4-B, if a single group (1) had a plan with an attachment point at $10,000 (line 1.2) and a plan with an attachment point at $20,000 (line 1.3), the total number of groups (line 1.22) would still be one (1), not two (2) because there is still only one employer being covered even though the employer has two separate health benefit plans. The unit of analysis is the employer group. So in contrast to the other column categories, this column may not sum total due to double counting. Instead, report the actual number of employer groups that would be true for each row category. The total number of groups covered in part 4-B, line 1.22, columns 2, 4, and 6 must balance to the total number of groups covered in part 4-A, line 1.1, column 2.

*Group Categories*

SMALL GROUP (1 to 50): Insured policies issued to a group organization of 1 to 50 employees.

LARGE GROUP (51 to 100): Insured policies issued to a group organization of 51 to 100 employees.

LARGE GROUP (101 or more): Insured policies issued to a group organization of 101 or more employees.

***PART 4-B: STOP-LOSS INSURANCE SPECIFIC ATTACHMENT POINTS (CONTINUED)***

**ROW DEFINITIONS**

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|---|---|
| NONE: | Enter the total number of members and groups protected under a stop-loss insurance policy without a specific attachment point (individual stop-loss deductible). |
| $10,000 – $19,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $10,000 and $19,999. |
| $20,000 – $29,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $20,000 and $29,999. |
| $30,000 – $39,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $30,000 and $39,999. |
| $40,000 – $49,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $40,000 and $49,999. |
| $50,000 – $59,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $50,000 and $59,999. |
| $60,000 – $69,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $60,000 and $69,999. |
| $70,000 – $79,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $70,000 and $79,999. |
| $80,000 – $89,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $80,000 and $89,999. |
| $90,000 – $99,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $90,000 and $99,999. |
| $100,000 – $199,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $100,000 and $199,999. |
| $200,000 – $299,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $200,000 and $299,999. |
| $300,000 – $399,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $300,000 and $299,999. |
| $400,000 – $499,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $400,000 and $499,999. |

***PART 4-B: STOP-LOSS INSURANCE SPECIFIC ATTACHMENT POINTS (CONTINUED)***

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| $500,000 – $599,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $500,000 and $599,999. |
| $600,000 – $699,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $600,000 and $699,999. |
| $700,000 – $799,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $700,000 and $799,999. |
| $800,000 – $899,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $800,000 and $899,999. |
| $900,000 – $999,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $900,000 and $999,999. |
| $1,000,000 – $1,999,999: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $1,000,000 and $1,999,999. |
| $2,000,000 OR MORE: | Enter the total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) of $2,000,000 or more. |
| TOTAL: | Enter the total number of members and groups protected under a stop-loss insurance policy. Note: Column 2, 4, and 6 “Number of Groups Covered” may not necessarily add up to the total number of groups reported in the totals of lines 1.22. Please see the definition of “Number of Groups” for more information. The total number of members and groups covered in part 4-B, line 1.22 must balance to the total number of members and groups covered in part 4-A, line 1.1. |

***PART 4-C: STOP-LOSS INSURANCE AGGREGATE ATTACHMENT POINTS***

This table is a measure of the number of individual members and groups that are in a self-funded health benefit plan covered by stop-loss insurance coverage broken out by aggregate attachment points (see Aggregate Attachment Points). It does not measure specific (see Specific Attachment Points).

**COLUMN DEFINITIONS**

| | |
|---|---|
| NUMBER OF MEMBERS COVERED: | Enter the total number of members in a group health benefit plan that is covered by stop-loss insurance broken out by an aggregate attachment point (aggregate stop-loss deductible). The total number of members covered in part 4-C, line 1.12, columns 1, 3, and 5 must balance to the total number of members covered in part 4-A, line 1.1, column 1. |
| NUMBER OF GROUPS COVERED: | Enter the total number of groups in a group health benefit plan that is covered by stop-loss insurance broken out by an aggregate attachment point (aggregate stop-loss deductible). "Number of Groups Covered" means a count of the number of employer groups with a particular type of health benefit plan. Unlike the other column categories, the counts in this column may not necessarily add up to the total number of groups reported in the subtotals and totals for a particular table. For example, in part 4-C, if a single group (1) had a plan with an attachment point at 85% to 89% (line 1.2) and a plan with an attachment point at 90% to 94% (line1.3), the total number of groups (line 1.12) would still be one (1), not two (2) because there is still only one employer being covered even though the employer has two separate health benefit plans. The unit of analysis is the employer group. So in contrast to the other column categories, this column may not sum total due to double counting. Instead, report the actual number of employer groups that would be true for each row category. The total number of groups covered in part 4-C, line 1.12, columns 2, 4, and 6 must balance to the total number of groups covered in part 4-A, line 1.1, column 2. |

***PART 4-C: STOP-LOSS INSURANCE AGGREGATE ATTACHMENT POINTS (CONTINUED)***

*Group Categories*

| | |
|---|---|
| SMALL GROUP (1 to 50): | Policies issued to a group organization of 1 to 50 employees. |
| LARGE GROUP (51 to 100): | Policies issued to a group organization of 51 to 100 employees. |
| LARGE GROUP (101 or more): | Policies issued to a group organization of 101 or more employees. |

**ROW DEFINITIONS**

| | |
|---|---|
| NONE: | Enter the total number of members and groups protected under a stop-loss insurance policy without an aggregate attachment point (aggregate stop-loss deductible). |
| 85% TO 89%: | Enter the total number of members and groups protected under a stop-loss insurance policy with an aggregate attachment point (aggregate stop-loss deductible) between 85% to 89% of expected paid claim costs. |
| 90% TO 94%: | Enter the total number of members and groups protected under a stop-loss insurance policy with an aggregate attachment point (aggregate stop-loss deductible) between 90% to 94% of expected paid claim costs. |
| 95% TO 99%: | Enter the total number of members and groups protected under a stop-loss insurance policy with an aggregate attachment point (aggregate stop-loss deductible) between 95% to 99% of expected paid claim costs. |
| 100% TO 104%: | Enter the total number of members and groups protected under a stop-loss insurance policy with an aggregate attachment point (aggregate stop-loss deductible) between 100% to 104% of expected paid claim costs. |
| 105% TO 109%: | Enter the total number of members and groups protected under a stop-loss insurance policy with an aggregate attachment point (aggregate stop-loss deductible) between 105% to 109% of expected paid claim costs. |
| 110% TO 114%: | Enter the total number of members and groups protected under a stop-loss insurance policy with an aggregate attachment point (aggregate stop-loss deductible) between 110% to 114% of expected paid claim costs. |
| 115% TO 119%: | Enter the total number of members and groups protected under a stop-loss insurance policy with an aggregate attachment point (aggregate stop-loss deductible) between 115% to 119% of expected paid claim costs. |
| 120% TO 124%: | Enter the total number of members and groups protected under a stop-loss insurance policy with an aggregate attachment point (aggregate stop-loss deductible) between 120% to 124% of expected paid claim costs. |
| 125% TO 129%: | Enter the total number of members and groups protected under a stop-loss insurance policy with an aggregate attachment point (aggregate stop-loss deductible) between 125% to 129% of expected paid claim costs. |
| 130% OR MORE: | Enter the total number of members and groups protected under a stop-loss insurance policy with an aggregate attachment point (aggregate stop-loss deductible) at least 130% or more of expected paid claim costs. |
| TOTAL: | Enter the total number of members and groups protected under a stop-loss insurance policy. Note: Column 2, 4, and 6 “Number of Groups Covered” may not necessarily add up to the total number of groups reported in the totals of lines 1.12. Please see the definition of “Number of Groups” for more information. The total number of members and groups covered in Part 4-C, line 1.12 must balance to the total number of members and groups covered in part 4-A, line 1.1. |

***PART 4-D: STOP-LOSS INSURANCE CARRIERS***

List the names of the commercial health insurance carriers that are providing stop-loss insurance coverage to the self-funded health benefit plans your company is administering as of Dec. 31, 2019. Include NAIC company codes where applicable.


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